DEPARTMENT OF INLAND FISHERIES AND WILDLIFE

DISABILITY MEDICAL EVALUATION

PLEASE PRINT OR STAMP CLEARLY

PHYSICIAN'S NAME:_____PHONE:_____

MAILING ADDRESS_____

CITY:_____ STATE:_____ ZIP CODE:_____

PATIENT'S NAME:_____

DIAGNOSIS DATE:_____

1. **IN "LAYMAN'S TERMS" PLEASE DESCRIBE THE NATURE/DIAGNOSIS OF IMPAIRMENT:**
   Please be specific about the patient's impairment. Describe only the impairment(s) that affect specific body functions needed to hunt, fish or trap. Such as: exiting a motor vehicle; standing, balance, walking or use of the arms; handling a firearm, bow and arrow or other equipment or properly identifying a target. For example, having a heart condition may not significantly impact the patient's ability to exit a motor vehicle and ability to walk a short distance to legally discharge a firearm.

   _____

   _____

   _____

2. **IS THIS A PERMANENT CONDITION? (Please circle one) YES NO**
   If no, please indicate the anticipated duration of impairment.

   _____

3. **PLEASE DESCRIBE THE PATIENTS FUNCTIONAL LIMITATION(S) RELATED TO IMPORTANT BODY FUNCTIONS NEEDED TO HUNT, FISH OR TRAP.**
   Please state clearly the patient's functional limitations that impact their ability to hunt, fish or trap. For example, if the impairment affects the patient's ability to hunt, please explain how the patient's functional limitations impact the essential functions of hunting, i.e., entering or exiting a vehicle; standing, balancing, walking and use of the arms; handing a firearm, bow and arrow or other equipment; properly identifying an animal or tolerating cold weather.

   _____

   _____

4. HOW SEVERE OR SUBSTANTIAL IS THIS FUNCTIONAL LIMITATION?

_____

_____

5. IN YOUR OPINION, DOES THIS IMPAIRMENT PREVENT THE PERSON FROM CARRYING OUT ESSENTIAL FUNCTIONS ASSOCIATED WITH HUNTING, FISHING OR TRAPPING?
Please circle one: **YES** **NO**

If YES, Please explain:_____

_____

6. HAS THE PATIENT BEEN PRESCRIBED ANY OF THE FOLLOWING AMBULATORY DEVICES?
If so, to what extent is the patient required to use the device(s):

Full-time/ Part-time/ Only under certain conditions. (Please explain below):

Wheelchair:
Canes: **State # of canes**_____
Walker:
Crutches: **State # of crutches**_____
Other:

7. IF APPLICABLE: Does the patient's impairment prevent them from handling a firearm or bow and arrow without the aid of adaptive equipment? (i.e. involuntary muscle spasms, loss of strength in arms, range of motion, etc.) **YES** **NO**
IF YES, PLEASE EXPLAIN:_____

_____

_____

I certify that the patient whose name appears on this application is currently under my care and has the impairment as stated.

_____
PHYSICIAN SIGNATURE DATE

RETURN APPLICATION TO: **Department of Inland Fisheries and Wildlife**
Deputy Commissioner
284 State Street, 41 SHS
Augusta, ME 04333
Tel: 207-287-5202 Fax: 207-287-6395